DAY SERVICES
REFERRAL AUTHORIZATION

SECTION I ***(To be completed by Service Coordination)***

Customer's Name: _____ **Referral Date:**_____

Social Security #:_____ **DOB:** _____

Medicaid #: _____ **Primary Contact Person:**_____

Primary Contact Person Address and Phone: _____

Home Address and Phone: _____

Service Coordinator (Please Print): _____

_____
Service Coordinator Signature

Address and Phone Number: _____

SECTION II REFERRAL TO PROVIDER FROM SERVICE COORDINATION

Provider Name: _____ **Phone:** _____

Provider Address:

YOU ARE HEREBY AUTHORIZED TO PROVIDE THE FOLLOWING NUMBER OF UNITS OF DESIGNATED SERVICES TO THIS CUSTOMER

WAIVER? ☐ **Yes** ☐ **No** *** FOR ALL WAIVER CONSUMERS, MR/RD WAIVER AUTHORIZATION FORM A-6 (Day Habilitation) or A-7 (Prevocational) MUST ACCOMPANY THIS REFERRAL BEFORE SERVICES MAY BE PROVIDED**

NUMBER OF UNITS AUTHORIZED FOR THIS CONSUMER: _____
(Please check the appropriate authorized service)

X	AUTHORIZED SERVICE *(Additional Pages May be Attached)*
☐	**DAY HABILITATION:** **Comments and Recommendations:** _____
☐	**PRE-VOCATIONAL:** *(MR/RD Waiver Form VR must accompany this referral before services may be provided)* **Comments and Recommendations:** _____

ADDITIONAL CONSUMER INFORMATION *(Additional Pages May be Attached)*
CRITICAL AND EMERGENCY INFORMATION: _____
HEALTH/MEDICAL INFORMATION: _____
CARE AND SUPERVISION INFORMATION: _____

Date Referral Received from Service Coordination: _____

_____
Day Services Signature

Title: _____